PATIENT ASSISTANCE PROGRAM APPLICATION

To Be Completed By Patient

Johnson & Johnson HEALTH CARE SYSTEMS INC.

To apply for assistance, complete this application, attach your most recent federal tax return and return by mail or fax.

Mail to: Patient Assistance Program, PO Box 221857, Charlotte, NC 28222-1857
Telephone: 800-652-6227 Fax: 888-526-5168

PATIENT INFORMATION

Name _____ Guardian Name (if appropriate) _____

Date of Birth _____ Gender ☐ Male ☐ Female Primary Telephone _____

Social Security # _____ Alternate Telephone _____

Address, City, State, ZIP _____

FINANCIAL INFORMATION (All Values Should Reflect Annual Amounts for Entire Household)

Salary/Wages/Unemployment $ _____ Value of Assets $ _____

Pension/Social Security $ _____ Other $ _____

(Include: checking & savings accounts, certificates of deposit, stocks & bonds, mutual funds, IRAs, cash, and the value of life insurance policies if you turned in your policies for cash right now. **Do not include: homes, vehicles, burial plots or personal possessions.**)

Supplemental Security Income $ _____

Social Security Disability Insurance $ _____ Check the applicable box:

Total Gross Annual Income $ _____ ☐ **Attached is a copy of my most recent federal tax return**

Household Size _____ ☐ **I do not file federal taxes**

(Number of people who contribute to or are dependent on your household income)

INSURANCE INFORMATION

Do you have any public or private insurance? ☐ Yes ☐ No

MEDICARE

Are you eligible for Medicare? ☐ Yes ☐ No

If "No", will you be eligible for Medicare in the next 12 months? ☐ Yes ☐ No

If "Yes", provide the date you will be eligible for Medicare _____

Medicare Policy # _____

Did Medicare benefits begin within the past 2 months? ☐ Yes ☐ No

Are you enrolled in a Medicare prescription drug plan? ☐ Yes ☐ No

Insurance Company _____ Plan Name / # _____

Telephone _____ Policy ID # _____

Are you eligible for the Low Income Subsidy for Medicare Part D? ☐ Yes ☐ No ☐ Unsure ☐ Application Pending

MEDICAID

Are you eligible for Medicaid? ☐ Yes ☐ No

If "Yes", are you eligible for prescription drug benefits? ☐ Yes - Medicare Savings Program-Only (e.g., QMB, SLMB, QI-1)

☐ No - Spend-down not reached

OTHER STATE/ GOVERNMENT

Are you eligible for other state/government programs that provide prescription drug benefits (e.g., SPAP – State Patient Assistant Program)? ☐ Yes ☐ No ☐ Applied ☐ Not Applied ☐ Application Pending ☐ Waitlisted ☐ Unsure

PRIVATE/HMO

Insurance Company N/A Telephone _____

Policy ID # _____ Group ID # _____ Subscriber Name _____

Does this policy cover prescription drugs? ☐ Yes ☐ No Date of Birth _____ Relation to Patient _____

APPLICANT DECLARING CHANGE IN INSURANCE COVERAGE

Johnson & Johnson Health Care Systems Inc. is a duly authorized agent for Janssen Ortho Patient Assistance Foundation "JOPAF". "I understand that JOPAF policy requires individuals with access to medicines through an affordable benefit to seek access through that benefit. As such, I promise that I will notify Johnson & Johnson Health Care Systems Inc. and its Patient Assistance Program within 30 (thirty) days by mail at Patient Assistance Program, P.O. Box 221857, Charlotte, NC 28222-1857, OR by telephone at 800-652-6227, OR by fax at 888-526-5168, if there is any change in the status of my eligibility to obtain any drug(s) that I will receive under this Patient Assistance Program through any other resource at any time during my participation in this Patient Assistance Program. I understand that this notification requirement would apply to circumstances including, but not limited to, changes in my eligibility to participate in the Medicare program [due to changes in my age (65+) or disability status (including end-stage renal disease)], or my enrollment in the Medicare Part D prescription drug benefit."

Please indicate your agreement with these terms by signing below.

Patient Signature _____ Date _____

APPLICANT DECLARING ACCURATE & COMPLETE INFORMATION

I promise that the information on this form is correct and complete. If needed, Johnson & Johnson Health Care Systems Inc. and its Patient Assistance Program (the "Program") may request and obtain information about my or my family's income to enroll me in the Program. I understand that the Program administrators reserve the right at any time and without notice to modify the application form; modify or discontinue any or all of the Program and the related eligibility criteria; or terminate assistance provided by the Program at any time."

Please indicate your agreement with these terms by signing below.

Patient Signature _____ Date _____

Referral Code (Internal Use Only)

PATIENT ASSISTANCE PROGRAM APPLICATION

To Be Completed By Physician

Johnson & Johnson HEALTH CARE SYSTEMS INC.

Complete this form and return by mail or fax. The Program needs to receive both the patient and physician information in order to process the application.

Mail to: Patient Assistance Program, PO Box 221857, Charlotte, NC 28222-1857
Telephone: 800-652-6227 Fax: 888-526-5168

Patient Name _____

PHYSICIAN INFORMATION

Physician Name _____ Telephone _____ Fax _____

Facility Name C/O LA - DEPT. OF MENTAL HEALTH Tax ID # _____

Business Hours 8:00AM - 4:30PM Office Contact Name _____ Medicare Provider ID # _____ National Provider ID # _____

Address City, State, ZIP 550 South Vermont Ave, Room 903 LOS ANGELES, CA 90020

PRODUCTS TO BE DISTRIBUTED (Check all applicable)

PHARMACY CARD DISTRIBUTION - Patients receiving assistance through the Pharmacy Card will need a valid prescription from their prescribing physician to access medication.

- ☐ AXERT® Tablets (almotriptan malate)
- ☐ CONCERTA® (methylphenidate HCl) Extended-Release Tablets CII
- ☐ DITROPAN® (oxybutynin chloride) Tablets & Syrup
- ☐ DITROPAN® XL (oxybutynin chloride) Extended Release Tablets
- ☐ DURAGESIC® (fentanyl transdermal system) CII
- ☐ ELMIRON® (pentosan polysulfate sodium) Capsules
- ☐ FLEXERIL® (cyclobenzaprine HC) Tablets
- ☐ LEVAQUIN® (levofloxacin) Tablets/Oral Solution
- ☐ RAZADYNE™ (galantamine HBr) Tablets/Oral Solution
- ☐ RAZADYNE™ ER (galantamine HBr) Extended-Release Capsules
- ☐ SPORANOX® (itraconazole) Capsules
- ☐ TOPAMAX® (topiramate) Sprinkle Capsules
- ☐ TOPAMAX® (topiramate) Tablets
- ☐ ULTRACET® (tramadol hydrochloride/acetaminophen) Tablets
- ☐ ULTRAM® (tramadol hydrochloride) Tablets
- ☐ ULTRAM® ER (tramadol HCL) Extended-Release Tablets

DIRECT TO PHYSICIAN DISTRIBUTION – Medications selected for Direct to Physician Distribution will be shipped to the physician's office. Patients deemed eligible for the Program are eligible for up to 12 months of assistance as long as they continue to meet eligibility requirements.

- ☐ BIAFINE® Topical Emulsion
- ☐ BICITRA® (sodium citrate & citric acid oral solution, USP)
- ☐ CENTANY™ (mupirocin ointment), 2%
- ☐ ERTACZO™ (sertaconazole nitrate) Cream 2%
- ☐ GRIFULVIN V® (griseofulvin tablets) microsize & (griseofulvin oral suspension) microsize Tablets/Suspension
- ☐ HALDOL® (haloperidol) Injection
- ☐ HALDOL® (haloperidol) Decanoate Injection
- ☐ MYCELEX® (clotrimazole) Troche
- ☐ NATRECOR® (nesiritide) for Injection
- ☐ NEUTRA-PHOS® (oral sodium & potassium phosphate mixture)
- ☐ NEUTRA-PHOS-K® (oral potassium phosphate mixture)
- ☐ NIZORAL® (ketoconazole) Tablets
- ☐ PANCREASE® MT (pancrelipase) Capsules
- ☐ PARAFON FORTE® DSC (chlorzoxazone) Caplets
- ☐ POLYCITRA®-K (potassium citrate & citric acid for oral solution, USP)
- ☐ POLYCITRA®-K Crystals (potassium citrate & citric acid for oral solution)
- ☐ POLYCITRA® LC (tricitrates oral solution)
- ☐ POLYCITRA® Syrup (tricitrates oral solution)
- ☐ REGRANEX® (becaplermin) Gel 0.01%
- ☐ RETIN-A® (tretinoin) Cream, Gel or Micro
- ☐ RISPERDAL® CONSTA® (risperidone) Long-Acting Injection
- ☐ RISPERDAL® CONSTA® (risperidone) Long-Acting Injection with three week oral RISPERDAL® therapy*
- ☐ SPORANOX® (itraconazole) Oral Solution
- ☐ TERAZOL® (terconazole) 3 Vaginal Cream or Suppositories
- ☐ TERAZOL® (terconazole) 7 Vaginal Cream
- ☐ URISPAS® (flavoxate HCl) Tablets

PHARMACY CARD OR DIRECT TO PHYSICIAN DISTRIBUTION - Check the preferred method of distribution when selecting products below. See limitations above.

RISPERDAL® (risperidone) Tablets/ Oral Solution ☐ Pharmacy Card or ☐ Direct to Physician

RISPERDAL® (risperidone) M-TAB™ Orally Disintegrating Tablets ☐ Pharmacy Card or ☐ Direct to Physician

DIRECT TO PHYSICIAN DELIVERY ADDRESS

If the shipping address is different from the physician's address, provide the shipping address below.

Facility Name C/O LA - DEPT. OF MENTAL HEALTH Telephone _____ Fax _____

Facility Contact Name _____ Business Hours 8:00AM - 4:30PM

Address, City, State, ZIP 550 South Vermont Ave, Room 903

PRESCRIBING INFORMATION (Attach additional prescribing information for each drug selected for Direct to Physician Distribution)

Patient Name _____ Product Name _____

Dosage _____ Sig _____ Quantity _____ Date _____

Number of Refills (maximum 12) _____ **State License # (required)** _____ **Physician DEA # (required)** _____

*** If this patient is not currently on an oral antipsychotic medication and requires three weeks of oral RISPERDAL®, please attach prescribing information for both oral RISPERDAL® and RISPERDAL® CONSTA®. The prescription information completed for continued section above may be RISPERDAL® CONSTA® therapy extending beyond three weeks.**

To the best of my knowledge, this patient does not have prescription drug insurance coverage (including Medicaid, county funded, or other public programs) for the product(s) listed above. Johnson & Johnson Health Care Systems Inc. requests that physicians not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer. No claim may be made to any third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician Signature _____ Date _____

Required for DURAGESIC® CII only:
"I have received a copy of the full prescribing information required for DURAGESIC® CII and I am prescribing this product for chronic pain."

Physician Signature _____

Date _____

Patient Authorization To Share Health Information

Johnson & Johnson HEALTH CARE SYSTEMS INC.

AUTHORIZATION TO SHARE HEALTH INFORMATION FOR PATIENT ASSISTANCE PROGRAM

Patients must complete this form before they can participate in the Patience Assistance Program.

I, _____, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for products provided under this program to Lash Group. Lash Group runs the Patient Assistance Program (the "Program") for Johnson & Johnson Health Care Systems Inc. Johnson & Johnson Health Care Systems Inc. manages the Program on behalf of its affiliates: Janssen, L.P., McNeil Pediatrics (Division of McNeil-PPC, Inc.), PriCara (Unit of Ortho-McNeil, Inc.), Scios Inc., Ortho-McNeil Neurologics, Inc., Ortho Women's Health & Urology (A Division of Ortho-McNeil Pharmaceutical, Inc.), OrthoNeutrogena (A Division of Ortho-McNeil Pharmaceutical, Inc.), and Johnson & Johnson Wound Management (A Division of ETHICON, Inc.). These affiliate companies make the products that are provided in the Program.

This information can include spoken or written facts about my health and payment benefits. It can include copies of records from my health care providers or health plans about my health or health care. Lash Group and Johnson & Johnson Health Care Systems Inc. will use and give out this information to see if I qualify for the Program and to run the Program. People who work for and with Lash Group and Johnson & Johnson Health Care Systems Inc. may also see my information, but they may use it only to help me get assistance with the costs of my drugs and to operate the Program. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Johnson & Johnson Health Care Systems Inc., but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group and Johnson & Johnson Health Care Systems Inc.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Name (Print) _____ Date _____

Patient Signature _____

If the patient cannot sign, patient's personal representative must sign below.

Patient Representative Signature _____

Describe relationship to patient and authority to make medical decisions for patient

_____

_____

A copy of this form must be provided to the patient.

PATIENT ASSISTANCE PROGRAM ADMINISTRATOR FOR THE PRODUCTS OF:

Janssen L.P.

Johnson & Johnson Wound Management — A division of ETHICON, INC.

McNEIL PEDIATRICS — DIVISION OF McNEIL-PPC, INC.

OrthoNeutrogena

ORTHO WOMEN'S HEALTH & UROLOGY — A DIVISION OF ORTHO-MCNEIL PHARMACEUTICAL, INC.

ORTHO-McNEIL NEUROLOGICS, INC.

PriCara — Unit of Ortho-McNeil, Inc.

scios

Clear entire form

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client/Previous Names | Birth Date | MIS Number

Street Address | City, State, Zip

AUTHORIZES:

Name of Agency

Street Address

City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

JANSSEN PHARMACEUTICA
Name of Health Care Provider/Plan/Other

P.O.BOX 222098
Street Address

CHARLOTTE, NC 28222-2098
City, State, Zip Code

INFORMATION TO BE RELEASED:

- ☐ Assessment/Evaluation
- ☐ Laboratory Results
- ☐ Entire Record (Justify)
- ☒ Other (Specify): PATIENT FINANCIAL INFORMATION
- ☐ Results of Psychological Tests
- ☒ Medication History/ Current Medications
- ☐ Diagnosis
- ☐ Treatment

PURPOSE OF DISCLOSURE: (Check applicable categories)

- ☒ Client's Request
- ☐ Other (Specify):

RISPERDAL PATIENT ASSISTANCE PROGRAM

Will the agency receive any benefits for the disclosure of this information? ☐ Yes ☒ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____
Month Day Year

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

_____ _____
Contact person Agency Name

_____ _____
Street Address City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Client / Personal Representative Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____
Month Day Year